

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005099</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/11/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>COLUMBUS REGIONAL HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2400 E 17TH ST COLUMBUS, IN 47201</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 30405 Facility Number: 005099</p> <p>Type of Survey: State Licensure Off Site HFAP Accreditation Survey</p> <p>Date of HFAP On Site Survey - Hospital full survey January 9 to January 11, 2012</p> <p>Date of ISDH off site review - - September 24, 2012</p> <p>Reviewer/Surveyor Deborah Franco RN, PHNS</p> <p>Based on review of the January 9 - 11, 2012 HFAP Accreditation Survey Report, it has been determined that Columbus Regional Hospital meets the requirements for Hospital Licensure in Indiana.</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1